STP analysis South Yorkshire and Bassetlaw

http://www.smybndccgs.nhs.uk/application/files/1514/8037/0832/South_Yorkshire_and_Bassetlaw_Sustainability_and_Transformation_Plan.pdf

The STP Process

Q1. Version Control:

- **Date of first publication;**
- **Subsequent publication of versions;**
- **Date of final/latest version;**
- **Official consultation launched/closed.**

No dates given for first publication, subsequent, or submission to NHS England but recorded as 11/11/16 on Health Campaigns Together website. This may be when it was made available publicly but not clear.

No mention of official consultation but state (p41), "Our high level planning assumes a significant reduction in demand for hospital services and potential changes to services which, if fully developed into cases for change, would require public consultation in the future."

However there does appear to be some 'isolated' consultation on changes to individual services; these include hyper-acute stroke, children's services and anaesthesia. Thus (p43), "We have already established a communications and engagement group with communications and engagement colleagues from across all partners. Strategically led by the Commissioners Working Together and STP programme management office communications and engagement team, the group has already successfully engaged with thousands of people during pre-consultation for hyper acute stroke and children's surgery services. Together, we developed a communications and engagement strategy to deliver these two public consultations, which are now underway, and we will use this as the foundation for our work to connect and talk with people about the plan."

Dates for these consultations are not given, and none of these relate to an overall plan for services which is what the STP purports to be. However, the STP does state with no further details (p15), "We plan to consult widely with staff, the public and our stakeholder on our strategic plan in Winter 2016."

It also states (p44), "The communications and engagement team within the programme management office of the STP will continue to provide strategic oversight and support for all communications and engagement as our plans are put into action and by building on relationships with the voluntary sector and Healthwatch organisations, will engage with the public, as key partners, on our plans and future proposals. We will take account of their views and feed these back into our plans before any further work takes place."

So it seems that the STP views engagement with voluntary organisations and Healthwatch as sufficient for public consultation purposes.

Q2.Stakeholder sign up:

- **Who has agreed it?**
- **Who has not agreed it?**
- **Dates of agreement could be affixed to all named stakeholders.**

The STP claims to have (p7), "a strong community of stakeholders, including more than 10,000 voluntary sector organisations, 208 GP practices, five local authorities, five clinical commissioning groups, five acute hospitals, two of which are integrated with their community services, two associate acute hospital trusts, four mental health providers, five Healthwatch organisations and two ambulance services."

It goes on to say (p14-15), "The interim governance approach has been as follows:

- STP guiding coalition – two South Yorkshire and Bassetlaw system wide events shaping and consulting on the plan
- STP executive steering group – all local authority and trust chief executives and clinical commissioning group (CCG) accountable officers meeting fortnightly and also as part of a two day discussion forum
- STP executive coordinating group – STP lead, plus accountable officer representatives from CCGs, chief executive representatives from trusts and local authorities and the workstream leads met weekly to take the plan forward."

And that (p15), "Central to the plan's development was the setting up of an STP programme office; bringing together the commissioner and provider Working Together programmes, along with local authorities. The STP programme office worked with the workstream leads to establish the main priorities and to show how South Yorkshire and Bassetlaw would meet the three aims of the Five Year Forward View and create a long term sustainable health and care system for the population."

P48 states the STP has been developed in consultation with CEs or accountable officers from a list of organisations including local authority officers (see Q10 for list). However no evidence is provided that these organisations have signed up to the STP itself, or that they were asked to.

The STP implies some cross-boundary working, stating,
We are also working closely with our STP associate partners in West Yorkshire, North Derbyshire, Nottinghamshire and Humber, Coast and Vale.

Q3. Does the STP seem to be introducing new governance arrangements that will delegate authority to new organisations?

- **Will decisions still be made locally?**
- **Are there proposals to create ACOs?**
- **Does the plan include integration with local government or an additional tier?**

This STP clearly anticipates major changes to governance so that one or more ACOs are eventually running services in the area (p12 "Our Journey to Accountable Care"). Provides timeline for development of local Accountable Care Systems in primary and community care (p46), and states (p45), "All of our localities are starting to develop accountable care.

Our CCGs are moving forward with plans, for example:
- Barnsley is six months into development
- Bassetlaw is shaping its direction through its integrated care board
- Doncaster is developing a local integration model
- Rotherham has set out a framework for jointly providing services
- Sheffield is forming neighbourhoods in primary care, central to its plan for accountable care."

STP talks of "New models of care focused on broad integration of services" (p12), and discusses combining of responsibilities across 'places' (Barnsley, Sheffield, Doncaster, Rotherham and Bassetlaw) through alliances between providers, between commissioners, and between local authorities (p7).

It states that through its governance system it will (p23),

- "Support delivery of the NHS Constitution and Mandate
- Decisions will be taken at the most appropriate level
- We will take decisions that are relevant and appropriate to take at South Yorkshire and Bassetlaw level
- CCGs and local authorities will retain their statutory functions and their existing accountabilities for current funding flows, but will be jointly accountable though South Yorkshire and Bassetlaw financial controls and performance and quality metrics
- Clear agreements will be in place between CCGs and local authorities that have agreed to work jointly or closer together to deliver services more effectively in each of our places."

In addition (p23), "The new interim governance system has:

- Reshaped current governance arrangements, which will run in parallel with partners' governance and help make decisions
- A Strategic Oversight Group will provide oversight governance of the Collaborative Partnership Board (CPB)
- A Collaborative Partnership Board (CPB) which sets the vision, direction and strategy for the SYB health and social care economy outlined in this plan
- An Executive Partnership Board (EPB Executive) which supports the CPB and will develop policy and make recommendations to the Board. It will be the engine that drives delivery of the plan and ensures business at the Board is transacted efficiently
- A Joint Committee of Clinical Commissioning Groups (JCCCGs) which commissions services at the South Yorkshire and Bassetlaw level to deliver the vision set out by the CPG. It will produce a commissioning strategy and commissioning intentions in line with the plan. The decisions it takes will be joint and binding
- An NHS Provider Trust Federation Board where the six acute trusts in South Yorkshire and Bassetlaw have joined together to allow them to work more effectively and efficiently, develop clinical strategy to deliver new models of care."

The STP goes on to state (p23), "We are also looking at:

- An overarching Provider Forum which will bring together NHS and non NHS providers (domiciliary providers, private sector health providers, voluntary and hospices) to be part of the development of new models of care

- Primary Care being represented at the CPB and EPB and through the newly formed Primary Care Advisory Group made up of representatives from dentistry, general practice, pharmacy and optometry."

The STP goes on to state (p25), "the members of these groups come from all statutory South Yorkshire and Bassetlaw health and social care organisations plus national bodies as appropriate (NHS England, NHS Improvement, Health Education England and others), as well as other providers and representatives from primary care, the voluntary sector and patients, including Healthwatch.

A key principle of the governance arrangements is that local commissioning will remain a local responsibility. The JCCCG will only take precedent over local decisions where it agrees that it would be more efficient and effective for decisions to be made at a South Yorkshire and Bassetlaw level.

Some national services (for example highly specialised services) will remain within the remit of NHS England, for practical and cost effectiveness reasons, and will be co-commissioned where the principle above applies".

This all suggests that these organisations have relinquished control of their businesses to joint bodies; however we doubt whether this is the case in reality, and there is no evidence in the STP that all these bodies have agreed far-reaching powers for the joint bodies listed.

Q4. Is there an explicit timetable:

- **For delivery of the STP?**
- **For obtaining agreement to it?**
- **For delivery of the changes that the STP proposes?**
- **List any short term deliverables in 2016/17.**
- **Is there start and end date? If so, what are they?**

The STP provides a timeline for changes to occur, from 2016/17 to 2020/21)p46-47) although no specific start or end dates are given. Decisions on these changes seem to have been taken and it is a question of taking them forward. But no specific dates are provided. No measurable deliverables are mentioned - other than to deal with a potential £571m deficit (p45) – and no dates are provided for delivery of an overall STP or for obtaining agreement to it. This may reflect a view that there is no need to gain agreement for these proposals.

Q5. Is there reference to a STP Board and its Chair/Leader? List who these are.

The STP document is signed by Andrew Cash (p5) who is STP lead as well as Chief Executive of Sheffield Teaching Hospitals FT. A full list of partners is given on p48.

No list of membership of the Board or other new governance bodies (see p23 and Q3 above) is provided in the STP.

Q6. Are the future costs of the STP process made clear? Are there projections for:
- **Budgets?**
- **Personnel?**

Nothing is made available.

The STP Content

Q7. Is the start point for the STP clear in terms of population at 2016?
- **Is there a needs analysis in STP (or reference to Health and Well Being Board needs analysis) for STP catchment area?**

The document states the overall 'registered' population Is 1.5m but no reference or date given for this, and no further breakdown (pp5,14).

There is no reference to a needs analysis or to work by HWB boards. However there are several references to the health of the population in general terms, and an objective to improve this. Sometimes this is mixed up with reductions in use of services eg on p16 when discussing Healthy Lives programme. Also provide some indication of factors that would affect health eg smoking, alcohol, childhood poverty, deprivation (pp9, 17) but no indication of any formal analysis of needs and relation to these factors, or how proposed changes will impact on this.

Q8. Does the plan reflect the national template ie:
- **Expansion of primary care? If so, are proposals concrete, costed and timetabled?**
- **New models of care and proposals for more self-care? If so, do plans rely on new digital technology?**
- **Preventative measures as way of reducing demand on acute services, and reducing deficits? If so is there an estimated timescale and value put on savings?**

Unlike many STPs, this one does not explicitly take as its starting point the approach set out in NHS Five Year Forward View identifying three 'gaps' – health and wellbeing, care and quality, and finance and efficiency. However it does refer to the Forward View (pp4,41), and acknowledges the 3 gaps in its 'Plan on a page' (p45).

Primary care
STP discusses more investment in primary care (pp18, 29, 46) but all rather nebulous and no costed or timetabled proposals. Nevertheless the STP states a 'belief'(p34), "We believe the investment in primary care will stabilise and eventually reduce the demand for some hospital services and it is at this point that we will be able to make a decision on reshaping our services, across all settings".

New models
STP also mentions 'new models of care' (p11,21,23,30,46), and states (p12), "New models of care will be focused on broad integration of services to best meet the needs of the local population".

However no indication of what 'new models' entails except on p29 where there is reference to an existing scheme, and in this case no details of timescale, investment, returns etc is given. Thus, "In Bassetlaw, the Larwood and Bawtry practices have collaborated to jointly develop a new model of care for their registered patients. The primary care home is a national pilot supported by NHS England and the NHS Confederation and is a form of multispecialty community provider".

Digital and IT services is mentioned as enabler on p19, and on p20 it is stated without further detail (except on p32 where it is stated digital records will be shared across community teams) that, "Technology and digital integration will also play a major role in helping shape the future of health and care services."

Helping people to self care is mentioned on p26, and again in context of people with LTC (p30).

Prevention

STP states (p4), "prevention will be at the heart of everything we do"(p4), and there is emphasis on reducing preventable mortality from cancer and heart disease through targeting smoking, inactivity and obesity.

On p7, STP states, "Prevention will be at the heart of everything we do – from in the home to hospital care - supported by our plans to invest in, reshape and strengthen primary and community services. We want to help people in our communities be as mentally and physically well as possible, for as long as possible."

One way the document proposes to prevent illness is (p16), "We will change the way we invest in services to help the thousands of people across our region who are long-term unemployed – working with them, and with employers, to increase the number of people who get into and stay in sustained, meaningful work."

But no further detail of how this will be done, what would be invested, expected returns or timetable is given.

There is further reference on p20 to a desire to keep people healthy, but no detail provided.

STP clearly states that prevention will result in a reduction in growth in demand for services over next 5 or 10 years (p28). For example, it states (p28), "By getting prevention right in cardiovascular disease alone, we could prevent 5,500 early deaths and free up £58 million to be spent differently."

But goes on to state (p28) "We will need to look closely at how we invest in preventing ill health", implying that there are no detailed plans yet. But it states a desire to increase spend on prevention and shift focus to outcomes through ACOs (p28).

On p29 there is a figure of £15m mentioned as investment in long-term unemployed, and further references to a desire to reduce alcohol, smoking, obesity thereby improving health. None of this is that radical but we find no detail provided of what costs will be, what will be saved, how much demand reduced, and to what timetable.

Nevertheless the document goes on to claim (p29) that by taking 'these actions' (actions that are not described in any detail) the following reductions will take place:

- "A 25% reduction in hospital admissions, GP visits and prescriptions related to coronary heart disease and stroke for 15-64 year olds.
- A 15% reduction in all other hospital admissions, GP visits and prescriptions for 15-64 year olds.
- A reduction in the under 18 conception rate from 31.9 conceptions per 1,000 females (2014) to 12 per 1,000 females by 2020 (reported in 2022).
- A reduction in the number of children and young people between the ages of 5-15 years that will go on to develop a clinically diagnosable mental health disorder."

No evidence is offered for this, no timetable given, no resource implications.

Q9. Overall, are the objectives of the STP clearly expressed in SMART terms (specific, measurable, assignable, realistic and time related)?

No, a set of objectives is listed on p45 that is the antithesis of SMART.

Q10. Clarity of plan: local context:
Provide any details of local stakeholders and details of historical, current and projected financial deficits and any long-standing issues, as available from STP.

STP provides list of local stakeholders – 25 separate organisations and 10 patient and third sector partners. Thus, STP states (p48), "STP has been developed in consultation with chief executives and accountable officers from the following organisations",

1. NHS Barnsley Clinical Commissioning Group - Lesley Smith, chief officer
2. Barnsley Hospital NHS Foundation Trust - Diane Wake, chief executive
3. Barnsley Metropolitan Borough Council - Diana Terris, chief executive
4. NHS Bassetlaw Clinical Commissioning Group - Idris Griffiths, interim chief officer
5. Bassetlaw District Council - Neil Taylor, chief executive
6. Chesterfield Royal Hospital NHS Foundation Trust - Simon Morritt, chief executive
7. Doncaster and Bassetlaw Hospitals NHS Foundation Trust - Mike Pinkerton, chief executive
8. Doncaster Children's ServicesTrust - Paul Moffat, chief executive
9. NHS Doncaster Clinical Commissioning Group - Jackie Pederson, chief officer
10. Doncaster Metropolitan Borough Council - Jo Miller, chief executive
11. East Midlands Ambulance Service NHS Trust - Richard Henderson, acting chief executive
12. NHS England - Moira Dumma, director of commissioning operations Yorkshire and the Humber
13. Nottinghamshire Healthcare NHS Foundation Trust - Ruth Hawkins, chief executive
14. Nottinghamshire County Council – Anthony May, chief executive
15. The Rotherham NHS Foundation Trust - Louise Barnett, chief executive,
16. NHS Rotherham Clinical Commissioning Group - Chris Edwards, chief officer
17. Rotherham, Doncaster and South Humber NHS Foundation Trust - Kathryn Singh, chief executive
18. Rotherham Metropolitan Borough Council - Sharon Kemp, chief executive

19. Sheffield Children's Hospital NHS Foundation Trust - John Somers, chief executive
20. Sheffield City Council - John Mothersole, chief executive
21. NHS Sheffield Clinical Commissioning Group - Maddy Ruff, chief officer
22. Sheffield Health and Social Care NHS Foundation Trust - Kevan Taylor, chief executive
23. Sheffield Teaching Hospitals NHS Foundation Trust, Sir Andrew Cash, chief executive
24. South West Yorkshire Partnership NHS Foundation Trust - Rob Webster, chief executive
25. Yorkshire Ambulance Service NHS Trust - Rod Barnes, chief executive

And in partnership with,

26. Healthwatch Barnsley - Adrian England, chair
27. Healthwatch Doncaster - Steve Shore, chair
28. Healthwatch Nottinghamshire - Jez Alcock, chief executive
29. Healthwatch Rotherham - Tony Clabby, chief executive
30. Healthwatch Sheffield - Judy Robinson, chair
31. Voluntary Action Barnsley - Christine Drabble, chief executive
32. Bassetlaw Community and Voluntary Service - Catherine Burn, director
33. Doncaster Community and Voluntary Service - Norma Wardman, director
34. Voluntary Action Rotherham - Janet Wheatley, chief executive
35. Voluntary Action Sheffield - Maddy Desforges, chief executive".

No actual financial figures given for organisations. There is statement in several places that system is financially unsustainable with a forecast deficit for 'our provider organisations' by 2020/21 of £571m (pp10,34) or £579m (p6). So there appears to be some inconsistency within same document.

In the financial summary it adds (p40), "If we do nothing to address our shortfall, £464 million would be the health service gap, while £107 million relates to social care and public health".

STP states (p21), "We aim to bring about financial sustainability through our plan. We plan to buy health, care and support services together, at first across our priority areas but increasingly across all services."

The scale of the 'financial challenge' is described in more detail onp40 as discussed in Q11 below. Here it states "Our financial challenge assumes that all NHS organisations within the STP will work within their budgets and make the savings they have planned for the financial year 2016/17." However, no details are given so we cannot review the accuracy of these statements.

No specific local issues are mentioned in either the identification of the financial gap or in achieving balance.

Q11. Clarity of plan: finances

- **Are full financial projections included, or financial appendices published?**
- **Are important details still to be published or withheld?**
- **Are savings targets broken down by service and provider?**
- **Are revenue implications for providers made clear?**
- **Are capital requirements made clear?**

The answer to the first 4 questions above is No; for the fifth there is no indication but we assume there must be more details that have not been published.

As stated in Q10, the STP claims (p34) "If we continue as we are, the forecast deficit for our provider organisations is around £571 million by 2020/21" of a total budget of £3.9bn. On p40 it is claimed that if nothing is done, there will be a deficit of £464m in NHS and £107m in social care and public health. A table is provided showing where savings will be made (but nothing about how). Headline measures to reduce projected £571m deficit are by making savings in the following areas:

Table 1: Areas of savings to meet projected deficit in 2020/21, £m

Areas of saving	£m
CCG Business as Usual	10
Medicines Management	25
CIPs /Carter	190
Urgent Care	31
Elective Care	76
Clinical areas	14
Specialist Services	44
STP investments	76
Local authority solutions	107
Total Savings	571

Note: rounding causes these not to sum to 571m

The STP states (p40), "Our financial gap takes into account local investments to deliver the GP and Mental Health Five Year Forward Views. We assume we will receive all of our £105 million indicative share of national sustainability and transformational funding by 2020/21 to support closing the financial gap. We have also assumed that hospitals will meet all the quality standards agreed with their CCGs."

However that is all the detail provided.

We note also that a large part of the plan to meet the financial deficit relies on activities that we would expect to be seen as happening anyway; eg CIP savings by hospital; Carter review saving. So in fact most of what is being discussed in this document as meeting the challenge is not dependent on the STP itself.

The STP states (p41), "Whilst our modelling gives us a balanced position, it also highlights that planning and rethinking and reshaping health and care services can result in swings

in surplus and shortfall positions across the individual hospitals, which may mean we need to change the flow of funding. We think that a system wide budget, as mandated by national planning guidance, will help with this.

Considerable further work is required to move to detailed business cases which will help us to assess whether the financial modelling is realistic and capable of being implemented."

This indicates that the STP is a long way from providing any kind of case for changing current services.

Q12. Clarity of plan: services

- **Are the service implications clear?**
- **Which services are cut back?**
- **Which expanded?**
- **List any acute services cut, sites closed.**
- **List any A&E departments closed.**
- **What staff posts are reduced?**
- **Community services cut/ sites closed, or opened**
- **Primary care services expanded**
- **Other out-of-hospital services expanded**
- **Staffing and service implications in terms of posts created, downgraded, or lost.**

No detail provided on any of this; it is mentioned that there will be reductions in demand for hospital services but not what the implications would be for hospital sites. The only indications of change are on p11 where it states, "All our hospitals have committed to carrying out an independent review of their services as part of wider work, looking at access, standards and quality which will inform new models of care."

And on p20, "Alongside investing in primary and community care, we have also committed to an independent review of our hospital services across South Yorkshire and Bassetlaw."

And on p34, "We believe the investment in primary care will stabilise and eventually reduce the demand for some hospital services and it is at this point that we will be able to make a decision on reshaping our services, across all settings. This will ensure we have strong and sustainable hospital services in the future."

And again on p34, "Any plans for changing our hospital services will be developed with the public, patients and carers. As we develop cases for change around potential service changes, we will engage with all our stakeholders – including the public - through the process and ensure their views and feedback are considered and included in proposals before we formally consult. This will also be informed by our independent review of hospital services, due to take place in 2016/17."

This all suggest either that a detailed plan has not yet been produced, or that it is not being shared with the public.

However, seemingly independently of the STP, the area is already consulting on consolidation of particular acute services on to fewer sites (although even at this point, that is not made crystal clear). Thus, with respect to children's surgery and anaesthesia, on p37,

"For some people, this may mean travelling further than their local hospital for the services we are proposing to change."

"Between Monday 3 October 2016 and Friday 20 January 2017, members of the public are invited to share their views on the three proposed options for the future of these services – with a final decision expected to be made by clinical commissioners in February 2017."

There is also a consultation on acute stroke services to the same timescale (p38).

Q13. Clarity of plan: Workforce
Is there a detailed plan to ensure an adequate workforce will be in place?

Although developing a workforce strategy and investing in the workforce is mentioned (p10) no plan is provided or discussed.

Q14. Is social care included? What assumptions are made?

Yes it is included but only mentioned in the context of 'health and social care'; budget quoted includes social care as do the workforce numbers. On p10 we find there have been large reductions in social care funding. Other than that we find little information on social care and none on how savings will be made.

Q15. Is there a model that describes the plan?
- **Has the model been made available?**
- **Are assumptions made clear?**
- **Do they appear realistic?**

There is no model provided in STP although it states (p41), "Based on national and international best practice and successful local programmes, our plans consider a number of ways of doing things differently. We have modelled the likely impact of these ways of working on our baseline, using the outcomes of similar interventions."

And refers to financial modelling on the same page. But nothing is provided for further scrutiny.

Q16. Is there any reference to evidence supporting the plan?
- **Is this robust and credible?**

There is no evidence referenced but some mention of findings that influence what the STP puts forward (p23, 30 34). So we cannot say if it is robust or credible.

Q17. Is there risk analysis?

- **If so, are risks quantified and probability attached?**
- **What are top three risks cited?**

No risk analysis is provided. The STP states (p41), "The result of this financial modelling suggests that we should be able to bridge our financial gap and achieve a balanced position by 2020/21. However, there is a very high degree of risk attached to delivery of some of the changes" (our emphasis).

But it goes no further than that. Most worrying is a statement on p19, "We put a lot of thought into the areas we wanted to prioritise, thinking about how we can work with staff, stakeholders and the public to be innovative and, where needed, radical about possible solutions. We recognise there would be a significant amount of work to do to move from a working hypothesis to a fully thought through and detailed plan for change and as such, have identified the risks that could impact on our ability to achieve our collective ambition."